STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

The reimbursement methodologies for the following services are contained in this attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Methods and Standards for Establishing Payment Rates for Non-Institutional Services

OUTPATIENT HOSPITAL SERVICES

a) In-state Outpatient Hospital Services

1. Outpatient Hospital: Reimbursement for covered services in the outpatient department of the hospital shall be determined by the Commissioner of the Department of Human Services.

2. Outpatient Hospital (Dental Services): Reimbursement for dental services performed in the outpatient department of the hospital shall be on a fee-for-service basis, consistent with the fees paid to private practitioners and independent dental clinics.

3. Outpatient Hospital (HealthStart): Reimbursement for HealthStart Health Support Services and Pediatric Continuity of Care shall be paid on a fee-for-service basis.

4. Outpatient Hospital (Renal Dialysis): Services for End-Stage Renal Disease (ESRD): Reimbursement for Renal Dialysis Services for ESRD shall be at 100 percent of the Medicare composite rate including any add-on charges.

5. Outpatient Hospital (Medicare Deductible and Co-insurance Amounts): Medicare deductible and co-insurance amounts shall be reimbursed at 100 percent.

6. Outpatient Hospital (Laboratory/Pathology): Most hospital outpatient department laboratory/pathology services are reimbursed on a fee-for-service basis using the Medicaid Laboratory/Pathology Fee Schedule. There are some exceptions for blood products and other laboratory services, such as pathology, that are reimbursed on a cost-to-charge ratio. Specimen drawing and collection are reimbursed separately.

7. All other outpatient hospital services shall be reimbursed according to the cost-to-charge reimbursement methodology. Final settlements shall be reduced for hospital outpatient capital costs by 10 percent and reasonable cost of hospital outpatient services (net of outpatient capital cost) shall be reduced by 5.8 percent as reported in the Medicare Cost Report (HCFA-2552). This reduction shall be calculated when the Medicare Cost Report (HCFA-2552) is finalized and if the report is amended. Interim reimbursement will continue to be reimbursed on the hospital's cost-to-charge ratio for the most recent prior finalized cost report and adjusted for the estimated impact of the implementation of this methodology. Final settlement calculations are based on the lower of costs or charges.

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b) Out-of-State Outpatient Hospital Services Only

1. Reimbursement for outpatient services in out-of-state approved hospitals will be based on the rate of reasonable covered charges approved by the Title XIX agency in the state in which the hospital is located. Medicare deductible and coinsurance amounts will be reimbursed at 100 percent.

2. Reimbursement for outpatient services in out-of-state non-approved hospitals is limited to an initial visit for emergency services and will be based on the rate of reasonable covered charges approved by the Title XIX agency in the state in which the hospital is located.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Services

LABORATORY SERVICES

Reimbursement shall be on the basis of the lowest professional charge, not to exceed an allowance determined reasonable by the Commissioner, Department of Human Services, and further limited by federal policy relative to payment of practitioners and other individual providers. In no event shall the charge to Title XIX from a laboratory exceed the lowest charge to other providers for the specific service.

Reimbursement for laboratory services in outpatient settings conforms with the lower limits set by Medicare as required by section 1903 (i) (7) of the Social Security Act.

Payment for Part B co-insurance and deductible shall be paid only up to the Title XIX maximum allowable (less any other third party payments).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Services

PHYSICIAN SERVICES

(Includes Dentists, Osteopaths and Optometrists)

Reimbursement for covered services shall be on the basis of the customary charge not to exceed an allowance determined reasonable by the Commissioner, Department of Human Services, and further limited by federal policy relative to practitioners and other providers. In no event shall the payment exceed the charge by the provider for identical services to other governmental agencies, or other groups or individuals in the community.

Physicians who are HealthStart providers will be reimbursed on a fee-for-service basis utilizing HCPCS codes developed for HealthStart. Physicians practicing in hospital outpatient departments may bill fee-for-service if they are unbundled, i.e., allowed to bill independently for professional services.

Reimbursement for immunization services will be based on the formula of Average Wholesale Price (AWP) of the pharmaceutical plus 15 percent, plus $2.00 for the physician's cost of dispensing the immunization.

Reimbursement of Level III HCPCS codes for injectable and inhalation drugs shall be based on the Average Wholesale Price (AWP) of a single dose of an injectable or inhalation drug or the physician's acquisition cost, whichever is less, when the drug is administered in a physician's office. The Title XIX maximum fee allowance for these drugs will be adjusted periodically by the program to accommodate changes in the market cost.

Payment for Part B co-insurance and deductible shall be paid only up to the Title XIX maximum allowable (less any other third party payments).

TN 98-18 Approval Date NOV 12 1998

Supersedes TN 95-1 Effective Date JUL 20 1998

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NORPLANT SYSTEM REIMBURSEMENT

Attachment 4.19B

1. Reimbursement for the Norplant System will be provided in the physician's office and will be reimbursed on a global fee for service basis for service which includes a component for the surgical services. The fee for service will be periodically increased to reflect the increase in the price by the manufacturer when provided by a physician in an approved setting.

2. Reimbursement is limited to the surgical component only when the physician provides the service in the hospital setting (either inpatient or outpatient).

TN 93-33 Approval Date NOV 24 1993

Supersedes TN New Effective Date JUL 1 - 1993

Reimbursement for Depo-Provera when used for contraceptive purposes shall be done in the following manner:

Reimbursement for this Level III HCPCS code is based on the Average Wholesale Price (AWP) of a single dose of Depo-Provera or a physician's acquisition cost, whichever is less, when the drug is administered in a physician's office. The Medicaid maximum fee allowance for this drug will be adjusted periodically by the program to accommodate changes in the market cost.

TN 93-34 Approval Date DEC 10 1993

Supersedes TN New Effective Date JUL 1 - 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Services

PODIATRIST, CHIROPRACTOR AND PSYCHOLOGIST SERVICES

Reimbursement for covered services shall be on the basis of the customary charge not to exceed an allowance determined reasonable by the Commissioner, Department of Human Services, and further limited by federal policy relative to practitioners and other providers. In no event shall the payment exceed the charge by the provider for identical services to other governmental agencies, or other groups or individuals in the community.

Payment for Part B co-insurance and deductible shall be paid only up to the Title XIX maximum allowable (less any other third party payments).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Services

CERTIFIED NURSE PRACTITIONER/CLINICAL NURSE SPECIALIST SERVICES

Reimbursement for covered services shall be on the basis of the customary charge not to exceed an allowance determined reasonable by the Commissioner, Department of Human Services, and further limited by federal policy relative to certified nurse practitioners and clinical nurse specialists. In no event shall the payment exceed the charge by the provider for identical services to other governmental agencies, or other groups or individuals in the community.

Reimbursement to HealthStart pediatric providers will be on a fee-for-service basis utilizing HCPCS codes developed for HealthStart.

Certified nurse practitioners/clinical nurse specialists practicing in hospital outpatient departments may bill fee-for-service if they are unbundled, i.e., allowed to bill independently for professional services.

Reimbursement for immunization services will be based on the formula of Average Wholesale Price (AWP) of the pharmaceutical plus 15 percent, plus $2.00 for the practitioner's cost of dispensing the immunization.

Reimbursement of approved Level III HCPCS codes for injectable and inhalation drugs shall be based on the Average Wholesale Price (AWP) of a single dose of an injectable or inhalation drug or the practitioner's acquisition cost, whichever is less, when the drug is administered in a practitioner's office. The Title XIX maximum fee allowance for these drugs will be adjusted periodically by the program to accommodate changes in the market cost.

Payment for Part B co-insurance and deductible shall be paid only up to the Title XIX maximum allowable (less any other third party payments).

HOME HEALTH AGENCIES-HOME CARE SERVICES

New Jersey Approved Agencies

Effective for services rendered on or after January 1, 1999, home health agencies shall be reimbursed the lesser of reasonable and customary charges or the service-specific statewide unit rates modified by the Division to reflect provider-specific rates for each unit of service provided to Title XIX fee-for-service beneficiaries. The provider-specific unit rates shall be calculated by adjusting the service-specific statewide unit rates to approximate the reimbursable cost the home health agency is incurring in providing covered services to Medicaid and NJ KidCare fee-for-service beneficiaries.

Effective for services rendered on or after January 1, 1999, through December 31, 1999, home health agencies shall be reimbursed 90 percent to 100 percent of allowable cost according to Medicare principles of reimbursement which are based upon the lowest of:

1. 100 percent of reasonable covered costs; or
2. the published cost limits; or
3. covered charges.

A final reconciliation shall be calculated by subtracting interim payments from reimbursable cost. Reimbursable cost, which represents the 90 percent to 100 percent range of allowable cost, is calculated as follows:

1. If the Title XIX total fee-for-service payment under the service-specific statewide unit rates in the aggregate is greater than the allowable cost, reimbursable cost is equal to the allowable cost.

2. If the Title XIX total fee-for-service payment under the service-specific statewide unit rates in the aggregate is less than or equal to 90 percent of the allowable cost, reimbursable cost is equal to the sum of the following:

i. 90 percent of the allowable cost excluding field security costs; and

ii. 95 percent of the Title XIX fee-for-service program's share of field security costs for the period in which the reconciliation is calculated. In order to receive this field security cost adjustment, each home health agency which incurs field security